ORTHODONTIC INFORMATION

MEDICAL ASSISTANCE ADMINISTRATION/DIVISION OF HEALTH SERVICES QUALITY SUPPORT
QUALITY UTILIZATION SECTION -ORTHO
OLYMPIA WA 98504-5506

Both Sides Of This Form Must be Completed and Submitted BEFORE Treatment.

Provider name and address:	PATIENT'S NAME LAST	FIRST	MI	SEX

PATIENT IDENTIFICATION CODE (PIC)

FI	MI	BIRTHDATE	LAST NAME	TB

DSHS Provider number:

PART I. TREATMENT REQUESTED (Check box below)

DATE REQUESTED:

- ☐ Maxillo-facial cleft deformity
- ☐ Full Treatment
- ☐ Transfer case
- ☐ Interceptive treatment
- ☐ Limited Transitional Treatment (mid-late mixed dentition)
- ☐ Special Review
- ☐ Advisory (If there is no request for treatment or appliances stop here)

☐ PREVIOUS TREATMENT PLAN?

ESTIMATED START DATE

TENTATIVE TREATMENT PLAN:

FUNCTIONAL CONCERNS:

TREATMENT PLAN (Following Case Study):

(There should be no other equally effective, more conservative and substantially less costly treatment available.)

THIS SECTION FOR MAA/DUS USE ONLY

☐ **Orthodontic case study and treatment request are authorized.**

☐ **Orthodontic case study request authorized. Requested treatment is not authorized at this time.** ***Submit case study for evaluation.***

☐ **APPROVED** ☐ **DENIED** ☐ **PENDED**

Refer to the cover sheet for the consultant's comments

Authorization Number:	
Orthodontic Consultant	Date

The authorization number must be entered on all billings and extension requests.

RETAIN this information sheet with case record.

RETURN a copy of this form to Orthodontic Authorization, QUS - Dental (address at top of form) with request(s) for extension of authorization.

Direct Authorization Questions to (360) 725-1671

ORTHODONTIC DIAGNOSTIC INFORMATION

Part II

Client Name:

Client Age:

Client's Chief Complaint:

STAGE OF DENTITION:

☐ Primary ☐ Permanent ☐ Mixed

ANTERIOR TEETH:

Overjet _____ mm

Overbite _____ mm

Open bite _____ mm

Midline _____ mm

Corset _____

POSTERIOR TEETH:

Angle Classification:

Skeletal Classification: (Circle One)

Class 1 Class 2 Class 3

Dental Classification: (Circle One)

Right: Class 1 E to E Class 2 Class 3

Left: Class 1 E to E Class 2 Class 3

Cross bite:

Indicate all teeth involved _____

CROWDING (Approximate) SPACING

mm	mm
mm	mm

MISSING & MALPOSED TEETH (List)

	Yes	?
Ectopic Eruption (Numbers of teeth excluding 3rd Molar(s): _____		
Missing: _____		
Malposed, Inclined, or Rotated: _____		
Impacted _____		
Ankylosed _____		
Supernumerary _____		
Malformed _____		

BRIEF INITIAL OPINIONS

HABITS?

MUSCULATURE: TONE & FUNCTION:

SYMMETRY of ARCHES?

TEMPOROMANDIBULAR DYSFUNCTION?

GOOD ORAL HYGIENE?

☐ Good ☐ Fair ☐ Poor

RESTORATION OR CARIES PROBLEMS?

OTHER MEDICAL or DENTAL PROBLEMS?

I certify that the information provided is true and accurate to the best of my knowledge.

PROVIDER SIGNATURE

DATE